Understanding Changes to Physician Practice Arrangements In Maine and New Hampshire
Executive Summary

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Executive Summary

Introduction

This report examines trends in the organization and ownership of physician practices in Maine and New Hampshire. The Office of MaineCare Services and the New Hampshire Medicaid Program have observed a trend in the conversion of physicians from private practice to other practice arrangements including Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), hospital-owned practices, and hospital outpatient departments. Faced with increased costs for care provided within these facilities,[♦] both Medicaid programs sought to understand more about these changes, including their magnitude, the forces driving them, and their short and longer-term implications.

Methods

There were four components to this study:

- a review of the literature to examine national trends in physician practice arrangements;
- analysis of several data sources to examine trends in Maine and New Hampshire;
- telephone interviews with contacts in other states to examine the extent to which they have experienced similar changes; and
- telephone interviews with professional associations, practice administrators, and physicians to examine the factors influencing the adoption of various practice arrangements.

Findings

Physician and Practice Characteristics

- Nationally, the supply of primary care physicians has declined in recent years. Declines in practice income and career satisfaction are apparent across all specialties. In Maine, physicians have fewer residency options and many experienced physicians are approaching retirement age. We suspect this is also true in New Hampshire.

- In Maine, a declining number of physicians are practicing in solo and group practices. Increasing numbers of Maine physicians are practicing in hospital owned practices, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs). National trends also indicate movement toward medium and large-sized medical groups and health care facilities. No data are available from New Hampshire to examine type of physician setting.

[♦] Throughout this report, we use facilities to refer to hospital outpatient departments, RHCs, and FQHCs.

- Nationally and in Maine, Medicaid, uninsured, and charity care patients are concentrated among facility-based providers. In Maine, fewer physicians are accepting MaineCare patients in recent years.

Physician Practice Arrangements

- We found collaborative relationships between physicians and hospitals or other facilities in Maine, New Hampshire and other states. These relationships overlap in that they either involve physicians becoming employees of hospitals or FQHCs or involve hospitals and FQHCs acquiring private practices or RHCs. We found several examples that show an evolution from private practice to facility-based care.

Factors Driving These Trends

Economic Factors

- Higher reimbursement is the greatest trigger of conversions from solo practice to other types of arrangements. A few interviewees observed that enhanced reimbursement under a facility allowed struggling practices to sustain themselves.

- Private practice physicians with a large Medicaid volume report that they cannot afford to absorb low Medicaid reimbursement.

- In addition to low reimbursement from Medicaid, physicians are concerned with low reimbursement from Medicare and commercial payers. Medicare physician payment has not increased in 10 years and the federal government has proposed a 10% reduction in Medicare physician payment.

- Substantial medical school debt also affects physician practice arrangements. The average new physician has $150,000 in medical school debt and is unlikely to assume the financial risk of running a small practice.

Physician Recruitment

- Hospital and other facility-based practices report that recruitment is a major factor behind decisions to buy or sell practices. Facility-based practices can offer an attractive employment package to physicians. A paycheck, benefits, and established office infrastructure have been important in attracting new physicians.

Administrative Burdens

- The complexities of practice administration and the need to implement costly and complex health information technology (HIT) systems have also factored into the trend towards facility-based practice arrangements.

Personal and Family Factors

- Sustaining a practice as a physician transitions to retirement was cited frequently as a reason to join an FQHC.

- Respondents noted that group practices can provide an advantage over small settings from a lifestyle and financial perspective. They offer a far less isolating approach to rural health care and interdisciplinary teams can serve a broader variety of patient needs, giving physicians less on-call time and greater collegial support.

Costs and Benefits of These Arrangements

Costs

- Respondents noted the physician productivity in employment situations, where physicians receive a salary, may decline. Independent practices typically pay physicians based on accounts receivable, directly reflecting patients seen throughout a physician's work day.

- Large group and employment arrangements may impose requirements that impact physicians' clinical work, such as length of appointment times and number of appointments in a day.

- The installation of EMR packages may compel physicians to practice in new and regimented ways, affecting their job satisfaction. Additionally, installation of EMR is a large infrastructure investment and is not likely to lead to immediate cost savings.

Benefits

- Large health facilities have enough physicians generating income that they achieve economies of scale for their billing, administration, and personnel staff. Large settings also provide financial security that can lead to other important goals, such as active participation in quality assurance initiatives and implementing health information technology systems.

- In some settings, such as FQHCs, the trend toward larger settings has contributed to expanded services and providers. Some respondents noted that these services may include dental, mental health, pharmacy programs, chronic disease management, and case management and in some cases has resulted in integrated, interdisciplinary patient care in multi-specialty group practices. In some cases, facilities have been able to re-capture MaineCare participation by previously hard-to-find providers, such as dentists and urologists.

- With solo practitioners less able to provide care and often limiting the number of Medicaid patients they see, Medicaid beneficiaries are becoming more concentrated among fewer, larger provider groups which are less likely to limit Medicaid patients.

Policy Implications

- There are few policy options available to Maine and New Hampshire to influence physician preferences in the practice of medicine. Increased reimbursement is unlikely to draw physicians away from facility-based practice, though it would support the physicians that remain in office settings and introduce equity in payment for services that differ only in location or arrangement.

- Since 2002 the Federal Health Center Growth Initiative has added new Community Health Centers/FQHCs and/or added new sites or expanded services at existing Centers. States' authority to influence these changes is limited to the designation of health professional shortage areas. Absent authority to plan or designate the development and location of these facilities, it is important that Maine and New Hampshire make their Medicaid access needs and priorities known to FQHCs, RHCs, and their associations to ensure consideration in the future development of new facilities and sites.

- Although Maine and New Hampshire cannot reverse the tide of changes in practice arrangements, they can work with practices to develop policy and other initiatives to promote access to high quality, efficient care for Medicaid beneficiaries. A starting point for this would be to examine the performance of practices throughout the state on key access, quality, and cost measures to determine whether these new arrangements do provide enhanced value for the Medicaid program.

- Access to services for Medicaid beneficiaries is tied to recruitment and retention of physicians. Our work suggests that the trend toward physician employment is driven in part by an effort to enhance physician recruitment and retention. This is thought to ensure access to primary and specialty care for Medicaid beneficiaries, particularly as solo practitioners move away from providing this care. It is important for Maine and New Hampshire to monitor physician recruitment and retention, particularly as they affect access to services for Medicaid beneficiaries.

- It is important for Maine and New Hampshire to consider whether these new practice arrangements are organized to deliver higher quality care through HIT or other practice-based initiatives in comparison to solo providers.